

High-quality universal public healthcare: beneficial for patients and much more

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Equity is widely accepted by the medical professions as a fundamental element of quality and providing equitable care has been included in the 2030 Agenda for Sustainable Development promoted by the United Nations.¹ However, the provision of universal coverage is a necessary but insufficient requirement for achieving this goal.² Several determinants of health have been described and the interactions among them are not a simple issue. The classical model developed by Dahlgren and Whitehead shows that individual lifestyles are embedded in social norms and networks, and in living and working conditions, which in turn are related to the wider socioeconomic and cultural environment.³ This model helps to explain the high vulnerability of the immigrant population, often attributed to social disadvantages translated into low socioeconomic status and consequently worse working conditions or housing. The manuscript published in the current issue of the *European Journal of Preventive Cardiology* entitled “Burden of Cardiovascular Risk Factors and Disease in 5 Asian Groups in Catalonia—A Disaggregated, Population-Based Analysis of 121,000 First-Generation Asian Immigrants” aims to evaluate the burden of cardiovascular risk factors and disease among 5 Asian groups living in Catalonia (Spain): Indian, Pakistani, Bangladeshi, Filipino, and Chinese. This burden is also compared to that observed in the local population (i.e., the remaining general population). This confirmatory analysis was made possible by the availability of anonymized data from the Health Department of Catalonia’s administrative database, which contains almost 5.5 million records.⁴

Figure 1 combines the results described by Satish et al. for the immigrant groups studied and the local population⁴ with data on the prevalence of four cardiovascular risk factors (e.g. diabetes, hypertension, obesity and tobacco use) in the five countries of origin (i.e. Bangladesh, China, India, Pakistan and Philippines) collected by the World

Health Organization.⁵ This comparison aims to show three realities regarding the relationship between three sets of populations (the immigrant groups studied, their countries of origin, and the local population of Catalonia) and the corresponding Health Systems, acknowledging the bias introduced by comparing non-standardized age data from the countries of origin with the age-standardized data from the Catalan database. The Spanish National Healthcare System offers universal, comprehensive healthcare that is free to patients at the point of delivery. Thus, universal coverage applies to the general population in Catalonia from birth or, for the immigrant population, from arrival to the country. Healthcare expenditure in Spain was 9.03% in 2014, according to World Bank data.⁶ In contrast, none of the five South Asian countries included in the analysis have a universal government-funded health system. Workers in China, India, and the Philippines are covered by a universal public insurance system but people who do not have a legal contract of employment and cannot register as unemployed (i.e. the most vulnerable group) may be ineligible for free health care. In contrast, insurance systems in Bangladesh and Pakistan are not universal. Not surprisingly, these two countries have the lowest total healthcare expenditure (2.82% and 2.61% of national gross domestic product, respectively) of the five countries assessed.⁶ Satish et al. observed a worse cardiovascular risk profile in the Bangladeshi and Pakistani population in Catalonia, compared to the local population, requiring preventive interventions adapted to these populations.⁴ In comparison, the countries with a universal public insurance system for workers report higher investments in healthcare (e.g. 4.69% in India, 4.71% in the Philippines, and 5.55% in China).⁶ The prevalence of cardiovascular risk factors among immigrants from these countries was, in some instances, lower than in the respective country of origin or even in the comparison population of Catalonia. This has been

defined as the “healthy immigrant effect” and explained by positive selection, mainly based on educational attainment, with positive effects on health outcomes and behaviors.⁷ In Catalonia, this effect was observed in immigrants from China, the country with the highest healthcare expenditure of all five analyzed, reinforcing previous findings that not only individual lifestyle but also myriad determinants of health and the complex interactions between them might have an effect on health outcomes.³

The adoption of new habits in immigrant populations has been related to the length of stay in the host country. As a result, this population tends to make lifestyle changes with consequences for health outcomes, either positive or negative.⁸ However, Satish et al. did not have the opportunity to observe these changes for two main reasons. On the one hand, the cross-sectional nature of the study with no follow-up did not allow this assessment. On the other hand, the analysis presented was only conducted in first-generation immigrants because this phenomenon is relatively recent in Catalonia.⁴

This study was possible due to the existence of a National Health System with universal coverage where the primary health care service has a central role, providing wide population coverage, regular follow-up, and a point of access to the healthcare system for all types of complaints.⁹ Thus, the creation of an exhaustive information system from the compilation of all primary care records offers an outstanding resource for use in epidemiological studies. The inclusion of the total population in such databases makes it possible to analyze data from specific minority groups (e.g. South Asian population in Catalonia), preventing a selection bias usually observed in studies with a smaller sample size.

Beyond calculating the cardiovascular disease burden in South Asian populations, the study performed by Satish et al. shows the utility of high-quality National Health Services with universal coverage.⁴ The beneficial effects of the provision of non-discriminatory assistance independently of sex, age, country of origin or socioeconomic status has been clearly shown.² However, this alone is not sufficient to reduce health inequalities. A recent example from Barcelona illustrates this controversial point. Despite the city's strong network of primary healthcare centers with universal coverage, the incidence of COVID-19 during the first wave in the most economically deprived district of Barcelona was 2.5-fold higher than in the district with the highest socioeconomic level.¹⁰ Thus, universal coverage is key, but other evidence-based actions are needed to reduce inequalities. The information provided by the primary healthcare databases, linked with other sources of data (e.g. official mortality registries, hospital discharges, environmental variables or socio-economic level of residential areas) is crucial to increase our knowledge of the determinants of health and the interactions between them. Definitively, the universal coverage that characterizes National Health Systems favors the availability of exhaustive data to researchers from such databases. Indeed, the final aim is to create the conditions that ensure good health and social care for an entire population through the definition of preventive strategies, promotion of healthy lifestyles, protection from diseases and design of targeted screening strategies. This is part of the United Nations Sustainable Development Goals number 3, Good health and well-being, which includes the achievement of universal health coverage and access to quality essential health-care services. In addition, a direct link can be made to Goal number 10, Reduced inequalities. Ensuring that no one is left behind requires universal policies paying attention to the needs of disadvantaged and

marginalized populations.¹ Nevertheless, the purely economic debate around the most efficient healthcare model will continue to generate constant political confrontation.

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FIGURE LEGEND

Figure 1. Prevalence of four cardiovascular risk factors in the country of origin (Bangladesh, China, India, Pakistan, Philippines),⁵ among immigrants from those countries, and in the local population.⁴

*Non age-standardized data

Figure 1.

